Abortion attempts without clinical supervision among transgender, nonbinary and gender-expansive people in the United States

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ABSTRACT

Background Transgender, nonbinary and gender-expansive (TGE) people face barriers to abortion care and may consider abortion without clinical supervision.

Methods In 2019, we recruited participants for an online survey about sexual and reproductive health. Eligible participants were TGE people assigned female or intersex at birth, 18 years and older, from across the United States, and recruited through The PRIDE Study or via online and in-person postings.

Results Of 1694 TGE participants, 76 people (36% of those ever pregnant) reported considering trying to end a pregnancy on their own without clinical supervision, and a subset of these (n=40; 19% of those ever pregnant) reported attempting to do so. Methods fell into four broad categories: herbs (n=15, 38%), physical trauma (n=10, 25%), vitamin C (n=8, 20%) and substance use (n=7, 18%). Reasons given for abortion without clinical supervision ranged from perceived efficiency and desire for privacy, to structural issues including a lack of health insurance coverage, legal restrictions, denials of or mistreatment within clinical care, and cost.

Conclusions These data highlight a high proportion of sampled TGE people who have attempted abortion without clinical supervision. This could reflect formidable barriers to facility-based abortion care as well as a strong desire for privacy and autonomy in the abortion process. Efforts are needed to connect TGE people with information on safe and effective methods of self-managed abortion and to dismantle barriers to clinical abortion care.

Key messages

- Transgender, nonbinary and gender-expansive (TGE) people face structural and social barriers to clinical abortion care.
- Nearly one in five TGE respondents who had ever been pregnant reported an attempt to end a pregnancy without clinical supervision.
- Efforts are needed to connect TGE people with information on safe and effective methods of self-managed abortion and to dismantle barriers to clinical abortion care.

INTRODUCTION

Transgender, nonbinary and gender-expansive (TGE) people (box 1) in the United States (US) plan for, carry and terminate pregnancies. At least 0.4%–0.6% of adults in the US identify as transgender. Many TGE people assigned female sex at birth and people with intersex conditions have and retain a uterus, ovaries and fallopian tubes, and some report sexual intercourse with sperm-producing partners. As a result, many TGE individuals and people with intersex conditions need pregnancy and abortion care. Yet, the specific family planning needs – particularly abortion – of these populations have been inadequately characterised.
We previously reported that 12% of a large sample of TGE respondents in the US reported at least one prior pregnancy; 29 21% of these pregnancies ended in abortion. 7 Estimates suggest that 462–530 transgender and nonbinary people had a facility-based abortion in the US in 2017; 30 however, to our knowledge, no data exist on abortion attempts or experiences among TGE populations that happen outside of clinical settings. To improve understanding of the universe of abortion experiences among TGE people in the US, we conducted a national quantitative survey. We hypothesised that TGE people would report considering and attempting abortion without clinical supervision.

**METHODS**

**Study population**

Between May and September 2019, we fielded an online survey about the sexual and reproductive health experiences, needs and preferences of TGE individuals who were assigned female or intersex at birth in the US. Eligible participants came from two sources: (1) the general public and (2) participants enrolled in The Population Research in Identity and Disparities for Equality (PRIDE) Study, an online national prospective cohort study of sexual and/or gender minority adults. The research platform, design and participant population of The PRIDE Study are documented elsewhere. 31 Across both populations, eligible participants included any TGE person who was assigned female or intersex at birth, who was 18 years or older, resided in the US or its territories and could read and understand English. Participants from the general public were recruited via social media, in-person TGE community events, academic conferences and the study website. Participants from The PRIDE study were recruited to this survey from their personalised PRIDE study dashboard after direct notification by email and/or text message.

**Data collection**

We designed and administered the survey through Qualtrics (Qualtrics; Provo, UT, USA). Survey domains included pregnancy history, abortion history and sociodemographic characteristics. We programmed the survey to allow participants to input the terminology they used for their own bodies, and then displayed these terms back to the respondent in relevant survey...
US$5000 in gift cards was distributed. A raffle to win a US$50 electronic gift card; a total of completing the survey, participants were entered into from the same device using the same browser. On Qualtrics’s features to guard against multiple responses. We utilised tions with the core research team through a collabo - PRIDE Study, co-

Research and Participant Advisory Committees of The Community Advisory Team of TGE individuals, as well as the 

Patient and public involvement
To ensure that this study represented the needs and interests of TGE community members, we recruited individual members of the public who identified as TGE for a community advisory team to contribute to the design, conduct, reporting and dissemination of the study.32

RESULTS
Characteristics of the study population
Overall, 1694 TGE responponents provided reproductive history data. These survey respondents were young (median 27 years, IQR 23–33 years), primarily white, and had a range of gender identities and sexual orientations (table 1). Of 210 respondents who had ever been pregnant, 76 (36%) reported considering abortion without clinical support, and a subset of these (n=40, 19%) reported attempting abortion without clinical support. Among respondents who reported attempting abortion without clinical supervision the median age was 32 (IQR 28–38) years, nearly all were insured, most identified as white, 40% were parents and 59% had completed 4 years at college or a graduate degree. The most common gender identities in this subset were genderqueer, nonbinary, and transgender man; most participants (75%) identified with “queer” as their sexual orientation, and four participants (10%) identified as intersex.

Methods and outcomes for abortion attempts without clinical supervision
Among the 40 respondents who reported ever attempting to end a pregnancy without clinical supervision, 35 (88%) described one or more methods used to do so. Methods reported fell into four broad categories: herbs (n=15, 38%), physical trauma (n=10, 25%), vitamin C (n=8, 20%) and substance use (n=7, 18%) (figure 1). Two of the ten individuals classified as using physical trauma reported either “uterine massage” or pressing “firmly” on their abdomen; other examples referenced insertion of objects
Table 1  Respondent sociodemographic characteristics, overall and by abortion history, in an online sample of transgender, nonbinary and gender-expansive (TGE) individuals assigned female or intersex at birth in the United States (n=1694)

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>All respondents (n=1694)</th>
<th>Reported a pregnancy (n=210)</th>
<th>Reported an abortion (n=67)</th>
<th>Reported considering non-clinical abortion (n=76)</th>
<th>Reported attempting non-clinical abortion (n=40)</th>
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## Table 1  Continued

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Continued
such as the following: “I tried sticking a needle into my front hole” (man/transgender man respondent; Middle Eastern/North African; Northeastern US). Less frequently mentioned methods included fasting (n=3, 8%), acupuncture (n=2, 5%), use of birth control or emergency contraception (n=2, 5%), continued use of testosterone (n=1, 3%), manual attempts to remove the mucus plug (n=1, 3%) and excessive physical activity (n=1, 3%). Four participants reported searching online for methods to end their pregnancy (10%): one used vitamin C, one used herbs, and two did not report the method used.

In write-in responses, 13 (33%) respondents shared the outcome of one or more abortion attempts from 14 pregnancies: nine pregnancies ended in miscarriage or the return of menses, four ended in a subsequent clinic-based abortion after their initial abortion attempt failed and one ended in birth. A participant who reported a miscarriage wrote:

I drank a lot of alcohol, took a mild overdose of my prescriptions, repeatedly hit my lower abdomen with a hammer, and then stopped eating for a few days. At the end of the week, I miscarried. [Genderfluid/genderqueer/nonbinary respondent; identified as intersex; white; region unknown]

Another respondent, for whom the abortion attempt was unsuccessful, described their experience:

I’d rather not share the details. It did not work, the pregnancy ended in a slightly premature healthy baby whom I am primary caregiver for (love him, don’t regret him, but do regret not being able to access abortion). [Genderqueer/nonbinary respondent; identified as intersex; white; Western US]

Context of abortion attempts without clinical supervision

In open-ended responses (box 3), several respondents described their reasons for attempting to end a pregnancy on their own without clinical supervision, including barriers to clinical care such as insurance coverage, gestational age limits, provider bias, as well as complications from comorbidities or the fear of a partner finding out. Other participants did not provide a reason. Some participants described more than one pregnancy for which abortion was attempted without clinical supervision. Five respondents (13%) described difficult situations that influenced their attempt to end a pregnancy without clinical supervision, including suicide attempts, intimate partner violence or other physical harm, or fear of harm to themselves. Some responses indicated a fear for personal safety if anyone discovered the pregnancy – a fear that precluded...
among other unsafe or ineffective methods. Notably, not a
Reported abortion methods ranged from ingesting herbs
vision, and that nearly one in five had attempted to do so.
more than one in three respondents had considered
intersex at birth who had been pregnant, we found that
In a national survey of TGE people assigned female or
DISCUSSION
the respondent from seeking care from a clinician at a
health facility.

Respondents who attempted abortion on their own after being denied clinical care
► “I was denied access to abortion for a tubal pregnancy
by a Christian doctor for my third pregnancy. I
attempted to use herbs and acupuncture and uterine
massage to end that pregnancy. Eventually able to
got to [clinic name] for termination. Had infection
and complications due to delay.” [Genderqueer/man/
transgender man respondent; Middle Eastern/North
African, white; region unknown]
► “I was raped, and refused abortion access as I was
past [state’s] cut off (with my [comorbidity], I didn’t
discover my pregnancy till 16 weeks). I ingested
copious amount of black and blue cohosh to induce
uterine contractions, used evening primrose oil to
soften my cervix, then attempted to remove my mucus
plug manually.” [Genderfluid/pangender/two-spirit
respondent; Cherokee; Midwestern US]

Respondents who attempted abortion on their own without accessing clinical care
► “I tested pregnant with three brands of sticks, I used
them at work and school and the store bathroom so
he wouldn’t see. I couldn’t go to the doctor to confirm
it. I was terrified I would be killed. I looked and read
online about the things people try, I did a lot to make
myself very sick very quickly. It was stupid, I could
have died. I spent a day and a half unconscious or
crying in the bathroom I felt so sick, more in bed. The
funny thing is he acted concerned. I cleaned it all off
of me and felt lucky. I had a normal period a couple
months after.” [Agender/genderqueer/nonbinary
respondent; white; Western US]
► “[I used] blunt force to abdomen. Considered drinking
poison, as my insurance did not cover an abortion.
Luckily, I was able to get on state insurance which did
cover the procedure, so it did not come to that. I 100%
would have done it. Dying was a better alternative
to forced pregnancy.” [Nonbinary respondent; white;
Western US]

This study is limited by convenience sampling, as no
population-based sampling frame exists for TGE people
assigned female or intersex at birth. Thus, the results
may not be representative of all TGE experiences with
attempting abortion without clinical supervision in the
US. Further, while 22% of respondents identified with a
race or ethnicity other than “white”, representation from
some racial and ethnic groups was low. Given established
disparities in access to clinic-based abortion34 this
limitation is particularly relevant. Additionally, because we
measured age and other sociodemographic characteristics
at the time of survey initiation and not at the time of the
abortion attempt, we cannot tie these characteristics to
any specific abortion attempt. Similarly, we did not ask
whether respondents identified as TGE at the time of their
pregnancy, which limited our ability to assess the role of
transphobia and cissexism in their abortion experience.
The strengths of this study balance the limitations. This
is the largest existing sample of TGE people reporting on
abortion attempts without clinical supervision. The study
had integral involvement of several community advisory
teams comprised of TGE individuals and recruitment from
community-dwelling as opposed to clinic-based
populations.

Our findings indicate that barriers to clinical abortion
care may lead to TGE individuals attempting to utilise alter-
native abortion methods (some safe, some highly unsafe)
without clinical supervision. This choice was sometimes
made out of preference for non-clinical methods; but in
more instances, the decision was made because clinical
care was not a safe or accessible option. Efforts are needed
to amplify organisations and platforms that provide high-
quality, evidence-based information about self-managed
medication abortion options, such as Abortion On Our
Own Terms, as well as mobile phone apps such as Euki.
Beyond medications, many community-based networks
use herbs to induce abortion; peer-reviewed data on
the safety and effectiveness of these herbal methods are
needed.18 For some TGE people, self-managed medication
abortion information may empower them to have a
safe, effective abortion in the setting and circumstances of
their choosing. For others, self-managed medication
abortion is a critical harm reduction strategy when an abortion
is needed, but clinical care is inaccessible.

In parallel, many systemic barriers need to be disman-
tled to ensure that clinical abortion care is an accessible
and affirming option for all TGE people. Abortion
providers should implement steps to improve the inclus-
vuity of abortion clinics for TGE patients, such as
adopting gender-neutral intake forms and signage as well
as using gender-inclusive language (eg, “people” or
“individuals” instead of “women”). Further, clinicians and counsellors could benefit from training on providing inclusive and affirming abortion care for TGE people. At the policy level, the long called-for issue of expanding health insurance coverage to cover the costs of abortion care could address reported financial barriers. Increasing health insurance coverage to cover the costs of abortion may be particularly impactful for TGE communities, as telemedicine may reduce logistical and discriminatory barriers to clinical abortion care while providing access to a preferred method of abortion.

CONCLUSIONS

Data from our study provide new and critical insights about non-clinical abortion experiences among TGE people including the nuanced and often fraught contexts in which abortion attempts take place. The reported experiences highlight systemic discrimination and barriers to abortion care for TGE individuals that clinicians, researchers, policymakers and advocates must urgently work to address. Building on the findings of this study, additional research is needed to understand how to facilitate information access so that any person who chooses to self-manage an abortion has the information to do so safely and effectively.

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